p.2

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		OMB NO. 0938-03 (k3) DATE SURVEY COMPLETED		
•		1		***	COMPLETED		
		99G224	B. WING_		05/08/2009		
CARECO	OVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 105 1/2 57TH STREET NE NASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES V MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES PREFERENCED TO THE API	COMPLETA		
W 000 II	NITIAL COMMENT	rs	W 000		<u> </u>		
6 ir na di	i, 2009 through Ma nitiated using the fi andom sample of f resident population isabilities. The findings of the standardian, interviews ne day program, and dministrative record 83.420(d)(1) STAF LIENTS The facility must devolicies and procedu	vey was conducted from May by 8, 2009. The survey was undamental survey process. A four clients was selected from in of seven men with various survey were based on lews with clients, one with staff in the home and at swell as a review of client and ds, including incident reports. F TREATMENT OF	W 149	GOVERNMENT OF THE DIST DEPARTMENT OF HEALTH REGULATION A 825 NORTH CAPITOL ST., WASHINGTON, D	HEALTH DMINISTRATION N.E., 2ND FLOOR		
Ba fai im he	esed on Interview a iled to ensure that iplemented policies alth and safety, fo	not met as evidenced by: and record review, the facility staff consistently s developed to protect client r five of the seven residents ts #2, #4, #5, #6 and #7)					
su	pident reports for in	153. Staff failed to prepare injuries of unknown origin #2 and #6, in accordance hagement policy.		1. See response to W153.	430/09		
an inv Cli dri driv	d record review, the restigate an April 6 ent #6. The invest ver who, by one ey ving recklessly at t	54.2. Based on interview le facility failed to thoroughly le 2009 incident involving ligation failed to mention the le witness account, was the time of the incident.		2. See response to W154.	6/30/09		
CATORY DIR	LECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA		TITLE	(X6) DATE		
perta	D. Juno	9	rector c	of Disability Jernios	6/5/09		

p.3

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES					FORM	05/26/2009 APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0397		
		09G224	B. W	// ING	<u> </u>	1	05/0	0/0000	
CAREC	PROVIDER OR SUPPLIER			50:	ET ADDRESS, CITY, STATE, ZIP 5 1/2 57TH STREET NE ASHINGTON, DC 20019	CODE	03/0	8/2009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	FLX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOUL HE APPRO	D RE	(X5) COMPLETION DATE	
W 149	Continued From pa	ge 1	W	149					
	3. Based on observine and record review, facility policy on transportar a. On May 7, 2009, revealed that facility Clients #5, #6 and # seat belt prior to belt van, in accordance wand facility policies, brought to the House surveyor, he instruct securing their seatbefanother vehicle report its seat belts at the b. According to an in 2009 and its correspondated April 13, 2009, to his forehead when while riding in the facility setting and the faction after findings of had not properly securing who proper	ration and interview and by staff failed to implement the tion safety, as follows: at 8:32 AM, observations staff failed to ensure that 7 were properly secured by ng transported in the facility's with District of Columbia law Once the observation was a managers attention by the ed the staff to assist in alts. It should be noted that reedly was undergoing repairs a time of the survey. Diddent report dated April 6, onding investigation report Client #6 sustained an injury his wheelchair "flipped" illity van. According to the a direct support staff and the RD) received disciplinary of neglect. Staff reportedly ared the client's wheelchair e RD reportedly had not re effectively trained on selchairs when riding in otted that an outside gnized the facility's failure to		i i t t	3. The Governing Body will exceedence Director follows polar ransportation safety by ensuring the policy and that the QMRP cow clients are securely seated in the van.	licy regard ig she is to	ing sined on	6/30/09	
	dentify and classify the coordance to their in the coordance to their furting the agency to reclassion to the coordance to reclassion.	nis incident as neclect in		 - -					
M CMS-2567	(02-99) Previous Versions Ob	colete Event ID: SROV11		Facility I	D: 06G224	Continues	no sheet Or		

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES): 05/26/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			:		APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIF	PLE CONSTRUCTION	(ACS) DATE S COMPL	
		09G224	B. W	NG			
NAME OF	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	L) US/I	08/2009
CARECO				50	5 1/2 57TH STREET NE ASHINGTON, DC 20019		•
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	IX .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	(X5) COMPLETION DATE
W 153	483.420(d)(2) STAF CLIENTS	F TREATMENT OF	W	153			
į	mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ct or abuse, as well as source, are reported dministrator or to other ce with State law through res.			: : :		
	Based on interview a and resident records that all injuries of unl immediately to the au Department of Healt Administration, for two	riot met as evidenced by: and review of incident reports is, the facility failed to ensure known origin were reported dministrator and/or the th (DOH), Health Regulation to of the seven clients or (Clients #2 and #6)					
į	The findings include:						
	interview with the Quebrofessional (QMRP) (aka House Manager been one injury of unwithin the past four mon April 30, 2009, stainches in length on Codoing personal care. "got a note from staffincident." Review of irreport revealed no evadministrator and/or limmediate notification ncidents reported to ishow evidence that the ported. During the	A pre-survey review of the State agency failed to			The Quality Management Director will staff on incident reporting and management will be assigned to attend incident nanagement training at DDS. All newlyre, and will commune to be, trained on it exporting and management during their of the staff of the	hired staff	6/3u/09

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				D: 05/26/2009 VI APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES		1	QMB NO	<u>). 0938-0391</u>
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JILTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	
		09G224	B. WING	G	0.51	80 MAAA
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		08/2009
CARECO	.			505 1/2 57TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
W 153	Continued From pa	ge 3	W 18	53:		
	every injury of unkn	own origin must be reported administrator and to DOH.	, ,,			
	reports revealed that discovered a scratch According to the inci- the scratch, applied	further review of incident t on January 21, 2009, staff n on Client #2's forehead. ident report, a nurse cleaned Neosporin ointment and then The incident report did not		2. See response to #1 above.		6/30/09
	document notification review of incidents notified to show evided been reported.	n of DOH and a pre-survey sported to the State agency noe that this incident had				
W 154	483.420(d)(3) STAF CLIENTS	F TREATMENT OF	W 15	4		<u> </u>
	The facility must have violations are thorough	e evidence that all alleged ghly investigated.				
- !!	Based on interview a failed to thoroughly in unknown ongin and/o	not met as evidenced by: and record review, the facility avestigate all injuries of ar incidents of neglect, for atts residing in the facility. and #6)				
į -	The findings include:			!		
; t ; \$; 6 ; 7 ; 1	he Qualified Mental i stated that facility pol of unknown origin mu 7, 2009, beginning at	at approximately 4:26 PM, Retardation Professional icies required that all injuries ast be investigated. On May 3:38 PM, review of incident evealed the following rigin:		I. See response to W153. The Qual Director will re-open the investigat to determine the source of the injur	ions to attempt	6/30/09
	n. Cross-refer to W taff discovered a scr	153.1. On April 30, 2009, atch 1 1/2 inches in length				

DEPAR CENTE	TMENT OF HEALT RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FO	ED: 05/26/2009 RM APPROVED NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	IPLE CONSTRUCTION	(XB) DAT	E SURVEY PLETED
		09G224	B. WING	<u> </u>	_	Elecisono
NAME OF F	PROVIDER OR SUPPLIER		[;	REET ADDRESS, CITY, STATE, ZIP C 505 1/2 57TH STREET NE WASHINGTON, DC 20018		5/08/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	on Client #6's right care. As of May 8, the injury had not be. Cross-refer to V staff discovered a storehead. There wo fithis injury had be. 2. On May 7, 2009 of incident reports a investigations reveal client #4 sustained riding in a facility vasupport staff who witime of the incident, a short while later, it 4:20 PM. He said to client's wheelchair the driver was termi was unclear if the didirectly to this incide limmediate review of investigation report, revealed that the 1:1 Director/House Man interviewed. Further showed no evidence had been interviewed the report). The investigated that the 1:1 histraps (improperly) to this incide stated that the 1:1 histraps (improperly) to the incides and the stated that the 1:1 histraps (improperly) to the incides and the stated that the 1:1 histraps (improperly) the stated that the 1:1 histraps (shoulder while doing personal 2009, the potential source of been investigated. V153.2. On January 21, 2009, scratch on Client #2's as no evidence that the source ben investigated. It beginning at 3:38 PM, review and corresponding aled that on April 6, 2009, an injury to his forehead while in. The client's 1:1 direct as riding in the vehicle at the was interviewed in the facility beginning at approximately he driver had secured the that day, since he was new elved training. The 1:1 staff had been placed on leave and inated for "restless driving". (It river's termination was related ant.) If the corresponding dated April 13, 2009, 1 staff and the Residence lager (RD/HM) were review of the investigation that the driver of the vehicle in the driver of the vehicle in that the driver of the vehicle in the	W 154	2. The staff who were responsible have been disciplined and/or retrisecuring seating for clients in the will be properly trained in tie-downheelchairs prior to operating the accompanying clients on the van	e for the incider ained in properl van. New staff wns for e van or	y
		M, Client #4's 1:1 was again				
vi CMS-2567	(02-89) Previous Versions (Obsolete Event ID: SROV11	Facili	ty ID: 09G224 If c	continuation she	of Page 5 of 12

	RTMENT OF HEALTH RS FOR MEDICARE							FOR	D: 05/26/2009 M APPROVED D. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION	LIER/CLIA NUMBER:	1	NULTIPLE CON ILDING	STRUCTION		3) DATE	
		09G2	24	B. WI	NG	· · · · · · · · · · · · · · · · · · ·	.	05/	08/2009
NAME OF	PROVIDER OR SUPPLIER D				505 1/2 57	RESS, CITY, STATE, 2 TH STREET NE GTON, DC 20019	(IP CODE	USI	09/2009
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W 154	Continued From paginterviewed for clarid driver had secured to the denied having be incident Manageme that the only administration was their Director (*) him that he would be leave, as a routine poor of the written and the 1:1 staff (into the Facility's 2007 in however, no addition before the survey en	incation. He repeated the wheelchair that been interviewed by int Coordinator (IM strative staff he specific placed on admir solicy. Improximately 10:1 the RD/HM agree interviews of both erview form, Attacticident Management information was	t afternoon. the IC), stating oke with oinformed istrative 5 AM (and d to seek the driver hment D to ent policy); s shared	W	154				
W 159	The facility's investig the 1:1 staff had bee the client's wheelcha The investigation als reglectful for not ens on properly securing should be further not Therapist documente training on properly s in response to the Ap 483.430(a) QUALIFII RETARDATION PROBLEM COORDINATE ACCORDING THIS STANDARD is Based on observation	in neglectful in not in property in the volume that staff we clients' wheelchaited having provided acting wheelchaited having provided acting wheelchaited having provided acting wheelchaited having project acting wheelchaited having programmed and monitored action professional mot met as evidentic property in the professional action professional mot met as evidentic property in the professional action p	securing rehicle. M had been retrained rs. It al istaff irs in vans, it. must be by a al.	W 18	59				
	review, the facility fail	ed to ensure that	each						
M CMS-256	7(02-99) Previous Versions Oi	bsolete E	vent ID: SROV11		Facility ID: 09G2	21	Manufacture.		

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		I AND HUMAN SERVICES MEDICAID SERVICES				FORM	05/26/2009 A APPROVED
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE S	
		09G224	B. WIN	G_		054	
CAREC				50	EET ADDRESS, CITY, STATE, ZIP CODE 05 1/2 57TH STREET NE /ASHINGTON, DC 20019	l US/I	08/2009
(X4) ID PREFIX TAG	i (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC EDENTIFYING INFORMATION)	(D PREFI) TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	N ID RE	(X5) COMPLETION DATE
į	Mental Retardation of four clients in the	Professional (QMRP), for two sample. (Clients #3 and #4)	W 1	59	· :		
: :	program was made prescribed plate gua evidenced below:	I to ensure that the day aware of Client #3's ard to assist with feeding as) ! ! !	1. The QMRP will make at least a mont cach client's day program, and will assi Residence Director to also make at least visit. The visit and findings, as well as actions needed, will be documented in effectord.	gn the a monthly	
i	#3 was observed to use a plate guard his dinner meal. The Observations condu May 7, 2009, at 11:3 from a foam divided AM, Client #3 was of to prevent food from brought the food tow food was observed to	to assist with feeding during ere was no spilling observed. cted at the day program on i3 AM revealed Client #3 ate plate during lunch. At 11:37 bserved to use his left hand falling off his spoon as he eard his mouth. At 11:41 AM, o fall off Client #3's plate as food up with his spoon.					<i>बिड्डचे ०</i> द
! ! !	11:43 AM confirmed left hand to support f spoon. Further inten that Client #3 was no equipment for feedin Case Manager by tel approximately 2:30 F	that Client #3 was using his that Client #3 was using his cod from falling off his wiew with DP staff revealed at prescribed any adaptive g. Interview with the DP ephone on the same day, at PM, revealed that he was not was prescribed a plate				Removal samena:	
1	Professional (QMRP) approximately 3:30 P	alified Mental Retardation on May 7, 2000, at M, revealed that she was 3 was without a plate guard					

PRINTED: 05/26/2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>DMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G224 05/08/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 1/2 57TH STREET NE CARECO** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 159 Continued From page 7 W 159 at the day program. Further interview with the QMRP revealed that she had not observed a lunch meal at the day program. Review of Client #3's records on May 8, 2009, at 12:06 PM revealed a medical consult dated July 6, 2008. According to the consult, Client #3 had an Occupation Therapy Evaluation dated July 6. 2008 that required an "adaptive plate guard to prevent spillage." 2. The QMRP will ensure that at least a weekly 2. Cross-refer to W252. The QMRP failed to review of data is completed, and that the review is ensure staff documented behavior data in documented. When data is missing or questionable, accordance with the behavior support plans of the QMRP will ensure that staff are re-trained in Clients #3 and #4. data collection. 3. Cross-refer to W192. The QMRP failed to 3. The QMRP will ensure that staff are trained in ensure that staff were competently trained on the client's dietary needs. Client #2's diet texture and nutritional supplement needs. W 192 ! 483.430(e)(2) STAFF TRAINING PROGRAM W 192 For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement the nutritional plan for one of four clients in the sample. (Client #2) The finding includes: The dinner meal was observed in the facility on May 7, 2009, beginning at 5:25 PM. Client #2

was served turkey cutlet (chopped fine), macaroni

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DEPAR CENTE	TMENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES		3	FOR	D: 05/26/2009 M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4	ULTIPLE CONSTRUCTION LDING	(X3) DATE	<u>0, 0938-0391</u> SURVEY LETED
		09G224	e, wa	IG	05	memnoo
CARECO				STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019		08/2009
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W 192	of bread cut diagonal and a tall beverage as "Ensure." The new was evidenced by the sevidenced by the sevidence of the se	els sprouts cut in half, 1 slice ally, fruit cocktail, apple juice glass of what staff referred to seed for additional staff training	W 1	1. The QMRP will ensure that the R. Director and all staff are trained in a dietary needs.	esidence Il of the client	is' \$\(\frac{30}{09} \)
	Client #2's medical nearlier that day. At a review of his physicial telephone order date. Nepro twice daily. A fincreased the supple daily. A third telephodated April 28, 2009 supplement to 2 cansalbumen level" Als documented having the physician, who confir April 28, 2009 order to order. On May 8, 2009, at a Qualified Mental Retails.	ecords had been reviewed approximately 3:00 PM, an's orders (POs) revealed a cd April 1, 2009 for 1 can april 10, 2009 order sment to 1 can three times one order (with prescription) was to "increase Nepro food is three times daily for o on April 28, 2009, a nurse selephoned the primary care med the latest order. The was Client #2's current diet ardation Professional				
<u>.</u> ((QMRP) was asked a	bout Novasource Renal				

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		HAND HUMAN SERVICES 8 MEDICAID SERVICES				FOF	ED: 05/26/2009 RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE HLDING	CONSTRUCTION	(X3) DATE	O. 0938-0391 E SURVEY PLETED
·		09G224	B. WI	NG	· .		Monaga
NAME OF	PROVIDER OR SUPPLIER		·!	505 1	ADDRESS, CITY, STATE, ZIP CODE 12 57TH STREET NE HINGTON, DC 20019	1 08	/08/2009
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	'UX	PROVIDER'S PLAN OF CORRECT (EACH, CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES.)	180 085	(X5) COMPLETION DATE
	TwoCal HN suppler #2 currently receive supplement, Client: #1 was tube-fed the #1 was tube-fed the The consulting Nutr facility that same da stated that Client #2 supplement. She w April 28, 2009 incret recommendation by she concurred with further confirmed the HN with FOS supple via G-tube, for nutrition on the clients' nutrition further discussion, sadditional training was facility managers. Bof staff in-service tramost recent nutrition documented on April interviews, however, had not been effective.	pred next to the Nepro and ments. She stated that Client of the Novasource #3 received Ensure and Client TwoCai HN. itionist was interviewed in the many beginning at 2:55 PM. She was still prescribed Nepro as previously unaware of the ase to 6 cans daily, as per the nephrologist; however, the recommendation. She at the Ross Nutrition TwoCai ement was given to Client #1 ional sustenance. In was interviewed just be presence of the QMRP and that she had trained staff and that she had trained staff and the acknowledged that as indicated, for staff and beginning at 4:00 PM, review ining records revealed the training had been 23, 2009. Observations and revealed that the training records revealed the records revealed that the training records revealed the records records revealed that the training records revealed	W	192			
: 	Nutritionist, at 3:25 P Client #2's bread count the case at dinne not have been given stated that she had to processor to ensure the Residence Direct	M, she stated that while ld be moistened (which was r on May 7, 2009), he should fruit cocktail. She further rained staff to use a food ground texture. At 3:32 PM, or was asked about their eplied "nobody is on a		2.	. See response to #1 above.		6/30/09

Marsha H. Thompson

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/26/2009 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G224 05/08/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 1/2 57TH STREET NE CARECO** WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE W 192: Continued From page 10 W 192 pureed diet." He retrieved the food processor from the pantry and added that he had not seen it used since he became RD, in November 2008. W 252: 483,440(e)(1) PROGRAM DOCUMENTATION W 252 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to document behavior data in accordance with the behavior support plans (BSPs), for two of the four clients in the sample. (Clients #3 and #4) The findings include: On May 6, 2009, at approximately 4:05 PM, I. The QMRP will re-train the staff on data Client #3 was observed to cry when the Qualified collection; the QMRP will monitor the data Mental Retardation Professional (QMRP) entered collection at least weekly, and provide re-training the facility and began speaking to all clients. On and discipline to staff if indicated. 130/09 May 7, 2009, at approximately 6:00 PM, Client #3 was observed again crying as surveyors departed from the facility. Interview with the QMRP at approximately 4:10 PM revealed that Client #3's exhibited this behavior to gain attention. Interview with the Residence Director/House Manager at approximately 4:15 PM, revealed that unexplained crying was a part of the Client #3's BSP.

FORM CMS-2567(02-99) Previous Versions Obsolete

On May 8, 2009, at 2:44 PM, review of Client #3's BSP dated November 29, 2008 confirmed that one of his targeted behaviors was unexplained crying. The BSP further revealed staff was to

Event ID: SROV11

Facility ID: 09G224

If continuation sheet Page 11 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/26/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G224 05/08/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **CARECO** 505 1/2 57TH STREET NE WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 252 : Continued From page 11 W 252 record target behaviors on the data collection sheets on every shift, every day. Review of the behavior data collection sheets, however, revealed that staff had not documented Client #3's crying behavior on May 6 and 7, 2009. In a follow-up interview with the QMRP on May 8, 2009, at approximately 3:00 PM, she acknowledged that staff had not documented the crying as required. There was no evidence that the data had been collected in accordance with the BSP. 2. On May 6, 2009, at approximately 5:20 PM, See response to #1 above. Client #4 was verbally redirected by his 1:1 staff 6/30/09 to stop spitting. This was observed during the medication administration. Interview with the 1:1 staff, at approximately 5:23 PM, revealed that the client had a BSP to address the targeted behavior of spitting. On May 8, 2009, at 9:19 AM, review of Client #4's BSP dated November 16, 2008 confirmed that he had a targeted behavior of spitting. The BSP further revealed staff was to record target behaviors on the data collection sheets on every shift, every day. Review of the data collection sheets, however, revealed that staff had not documented Client #4's observed spitting episode on May 6, 2009. In a follow-up interview with the QMRP and Residence Director/House Manager on May 8, 2009, at approximately 4:30 PM, they acknowledged that Client #4's 1:1 staff did not document the spitting behavior as required. There was no evidence that the data had been collected in accordance with the BSP for Client #4.

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PRINTED: 05/26/2009

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **B. WING** HFD03-0248 05/08/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE CARECO **WASHINGTON, DC 20019** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG DATE DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure survey was conducted from May 6. 2009 through May 8, 2009. The Group Home for Persons with Mental Retardation (GHMRP) had a resident population of seven men with various disabilities. The findings of the survey were based on observations, interviews with residents and one guardian, interviews with staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports. 1022 3501.5 ENVIRONMENTAL REQ / USE OF 1022 SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure windows were equipped with curtains, shades or blinds that were clean and in good repair. The finding includes: I. The Director of Operations will direct On May 8, 2009, at approximately 5:05 PM, an maintenance to supply and mount a curtain, plind, environmental walk-through of the interior of the or shade to cover the windows in the doors. GHRMP revealed the front door window was 6/30/09 covered with a piece of cardboard box. Further observations revealed a piece of white paper covered the window on the back door. Interview with the Residence Director acknowledged that the windows to both doors should have been covered with curtains, blinds, or shades. ealth Regulation Administration (Xd) DATE BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE Director of Distility Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI B. WING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPL	ÆR	f .		STATE, ZIP CODE	ļ			
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1082 Continued From	1 page 1		1 082			!		
1 082 3503.10 BEDR	OOMS AND BATHROOF	us	1082			: 		
equipped with to	that is used by residents pilet tissue, a paper towe of for hand washing, a mir ig.	land cup		The QMRP will ensure that the bathroccups and cup dispensers.	oms have	6/30/09		
Based on obserting failed to ensure cup dispensers. The finding inclusion	ides:	facility pped with			٠			
interview with th 2009, beginning	onmental inspection and e Residence Director on at 5:00, revealed the ha ed by the residents failed spensers.	May 8, Ilway						
1091 3504.2 HOUSE	KEEPING		1091	·				
i be well construc	nd maintenance equipm ted, properly maintained e function for which it is	and						
Based on observ GHRMP failed to	not met as evidenced by: /ations and interview, the o maintain the interior and HMRP in a safe, clean, c anitary manner.	e						
The findings incl	ude:							
Observation and Director during the latter Regulation Administration	interview with the Reside environmental walk th	ence rough				; 		

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PRINTED: 05/26/2009 FORM APPROVED Health Regulation Administration (XS) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0248 05/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 505 1/2 57TH STREET NE **CARECO** WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY [091 1091: Continued From page 2 on May 8, 2009, beginning at 5:00 PM, revealed the following. I. Maintenance will replace the sink stopper. 1. The sink stopper located in bathroom #1 was observed to be broken. 2. Maintenance will repair the hole in the wall in 2. Bathroom #2 was observed to have a foot and the bathroom at the door stopper, and will install a half wide hole in the wall, where the door stopper cushion for the stopper to prevent future damage to on the back of the door met the wall. the wall. 3. The carpet in the living room area located 3. Maintenance will replace the damaged carpet. near the sofa nearest the front door was observed to have a two and half foot tear. The tear presented a potential trip hazard. 4. Maintenance will repair the hole above the 4. There was a hole, approximately four inches exterior front door. wide, in the overhang outside of the facility's front entrance door. 5. The cement sidewalk outside of the side 5. Maintenance will arrange for the sidewalk to be 6/30/09 entrance was severely damaged, with 3 sections repaired. of broken cement measuring 3 feet by 3 feet each. The uneven surface presented a potential trip hazard. 1092 1092 3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents Maintenance will exterminate the facility (for ants 6/30/09 and other insects). and vermin. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure it was maintained free of insects. The finding includes:

Health Regulation Administration

During the May 6, 2009 Entrance Conference, at approximately 4:30 PM, the Qualified Mental Retardation Professional (QMRP) and

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		HFD03-0248					5/08/2009
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1203	had been no reports vermin inside the fall however, live ants with dining room table at kitchen, living room the QMRP and RD. observed throughout days of survey. Into 2009, at approximal exterminator was la 2008. Although the a contract with a pe	(RD) both stated that is of any insects, rode icility. A short time is were observed crawlind floor, as well as in, and in the office ship, and in the facility on the kerview with the RD of tely 4:00 PM, revealest in the facility Nove RD stated that the first control company, receipts and/or a seest. EL POLICIES all discuss the contents of the employee at the teleast annually thereated and record review, the current job descriptive current in the personnologies and consultant of the pers	ents or ater, ing on the ing on the ared by in ast two in May 8, ed that an ember acility had he was ervice on the of job beginning after. PM, the all agreed is lew of 2009, iMRP ions for twere	1 203	The Human Resources Director will prodescriptions for all staff.	ovide job	4/3/109
ealth Regula	tion Administration			# s	ROV11	Facation	uation sheet 4 of 10

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0248		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COMPL	ETED
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1 206	Continued From pa	ge 4		1206				
1206	3509.6 PERSONNE	EL POLICIES		1 206		İ		
	annually thereafter, certification that a h performed and that	or to employment an shall provide a phys ealth inventory has b the employee's hea her to perform the re	ician 's een ith status					
	Based on interview GHMRP failed to er annual health certifi		ıe !					
	The findings include) :			-			!
To the control of the	Qualified Mental Re to make available for records for all emploincluding evidence of inventories. Review	of annual health certi	al agreed lel ls, ficates/ cords on	. •	·			
į	There were no himade available for r support staff (S7 and		direct		The Human Resources Director will all staff, nurses and consultants have cu inventories/certificates on file.	ensu rren	t health	A50/69
İ	 The health certification of the remaining 15 expired, as follows: (S2 expired on 3/3/0 	direct support staff h			2. See response to #1 above.			6/30/09
	 The health certification of the 7 facility nurse (N1 expired on 2/14) 	es had expired, as fo			3. See response to #1 above.			6/30/09
ealth Regula TATE FORM	tion Administration			•	D0144			

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AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM HFD03-6248		(X2) MUL A. BUILDI B. WING		COMPL	DATE SURVEY COMPLETED 05/08/2009	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		50.2000	
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1 206	Continued From pa	_		1206				
;	4. The health certif	· icate/ inventory on file orker had expired on A	for the opril 15,		4. See response to #I above.		6/30/09	
•	5. The health certificonsulting Nutritioni 12, 2008.	icate/ inventory on file ist had expired on Sep	for the tember		5. See response to #1 above.		6/30/09	
l 229	3510.5(f) STAFF TE	RAINING		1229			!	
	Each training progra limited to, the follow	am shall include, but n ing:	ot be		See response to federal deficiency W19	92.	6/30/09	
	residents to be serve to, behavior manage	elated to the GHMRP ed including, but not li ement, sexuality, nutri nmunications, and ass	mited tion,					
	Based on observation review, the facility fa effectively trained to	met as evidenced by: on, staff interview and illed to ensure staff wa implement the nutrition residents in the sample	ss onat		•			
	The finding includes	:					1	
-	May 7, 2009, beginn was served turkey or macaroni and chees half, 1 slice of bread apple juice and a tall referred to as "Ensur staff training was evi	e, Brussels sprouts of out diagonally, fruit of beverage glass of wheel. The need for additional denced by the following	dent #2 ut in ocktail, nat staff itional lg:					
		at 5:37 PM, a can of N	lepro			-	· 	
alth Regula ATE FORM	itlon Administration		. 90	» s	ROV11	V continuati	on sheet 6 of 10	

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1 229	Continued From page	ge 6		1 229	DETICIENCY		<u> </u>
T R SR	renal supplement war and presented to the and staff assisting a RD shook his head, the resident's supplement, however excently. The RD was to a supply of Ross I FOS supplement. He is a supplement. He is a supplement of Resident #2's medical reviewed earlier that PM, review of his phyrevealed a telephone of the can Nepro twice daincreased the supplement of 2 cans allow and the supplement of 2 cans allow mented having the supplement of the part of	e Residence Director to the dining room tab stating that was no learnent. He stated that say had received Neper, it had been changent in the pantry and Nutrition TwoCal HN at efforther stated that of the TwoCal HN at efforther stated that of the TwoCal HN at efforther stated that of the TwoCal HN at efforther stated that of the TwoCal HN at efforther stated that of the TwoCal HN at efforther stated April 10, 2009 and records had been day. At approximates visician's orders (POs efforther to 1 can three to ender (with prescrives to "increase Neper three times daily for the on April 28, 2009, a elephoned the primared the latest order. Was Resident #2's cultiported the Novasource Rentry. The Novasource Rentry. The Novasource dinext to the Nepro ents. She stated that received the Novasource fied the TwoCal HN.	(RD) le. The longer later onger				
ıa.	he consulting Nutritio cility that same day, I	nist was interviewed beginning at 2:55 PM	in the I. She				

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Health F	Regulation Administra	ation						- Orași	AFFICOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUT		(X2) MULT A. BUILDII B. WING	NG _	STRUCTION	(*	DATE S COMPLI	
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1 229	stated that Resident supplement. She was April 28, 2009 incre recommendation by she concurred with further confirmed the HN with FOS supple #1 via G-tube, for note LPN Coordinate moments later, in the Nutritionist. She stated to the residents' nutritier discussion, as	t #2 was still prescrit ras previously unawars ase to 6 cans daily, and the recommendation at the Ross Nutrition ament was given to furtitional sustenance for was interviewed justed that she had train tritional supplements the acknowledged that sindicated, for staff deginning at 4:00 PM aining records reveal at training had been the significant of the training had been the significant of the training had been the significant of the training had been the training had been the training had the tr	re of the as per wever, She TwoCal Resident St MRP and ned staff After at f and , review ed the	1 229					
	2. During the May & Nutritionist, at 3:25 I Resident #2's bread was not the case at should not have beefurther stated that si food processor to er PM, the Residence their food processor pureed diet." He ret from the pantry and used since he becar 3519.10 EMERGEN	PM, she stated that victual be moistened dinner on May 7, 200 m given fruit cocktail, he had trained staff to sure ground texture. Director was asked at the replied "nobody rieved the food prock added that he had not me RD, in November	white (which D9), he She Duse a At 3:32 bout is on a essor of seen it 2008.	270					
	In addition to the repeach GHMRP shall n Health, Health Facilition Administration	orting requirement in notify the Department	3519.5, t of	379	Quality N incidents	onse to federal deficiency Management Director will are reported to the Depa acilities Division per regi	ll ensure i	hat all	i /30/04
TE FORM	I		5000	S1	20V11		₩.		makeet 8 of 10.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE (DENTIFICATION NU		ERVCLIA IMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3	(C3) DATE SURVEY COMPLETED	_
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1 379 Continued From pa	oe 8		1379			4
unusual incident or interferes with a restarrangement, well to places the resident be made by telephological to be writted to be writted.	event which substantident 's health, welforing or in any other at risk. Such notification within an otification within ars or the next work of	are, living way tion shail shall be				
Based on interview and resident record: that all incidents that residents' health or immediately to the I Health Regulation A four residents in the	safety were reported Department of Health dministration, for one sample. (Resident #	(DOH),				
The findings include	:			•		ł
On May 6, 2009, at a interview with the Quarter Professional (QMRF) (aka House Manage had been in and out during the previous upre-survey review of to the State agency in (May 2, 2009) trip to	Jalified Mental Retard) and Residence Din r) revealed that Resident of the hospital seven month. However, a incidents that were read indicated only on	dation ector dent #1 al times eported				
j Subsequent review of records and incident 2009, beginning at 1 following:	reports, beginning of	n May 7				
He was taken to a (ER) on November 2 admitted to the hospi indicated his diagnos	5, 2008 and subsequital. The discharge s	ently Immany				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A, BUILDIN		(X3) DATE S COMPL		
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l 379	Continued From pa and "aspiration of gu the fecal impaction." 2. He was taken ag	astric contents secon		1379	;		
	and subsequently a discharge summary included "emesis, b and "constipation."	dmitted to the hospit indicated his diagno ilateral aspiration pro	al. The eses eumonia"		:		
	3. He returned to the 2009 and subseque summary indicated in "gastritis, esophagituleer in the body of There was no evider	ntity admitted. The d his diagnoses includ is" and "single non-b the stomach." nce that the three	ilscharge ed leeding				
, ,	aforementioned ER had been reported to		OONS				
; ; ;							
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aith Regula ATE FORM	ation Administration	•	59	** SI	ROV11	# continuatio	n sheet 10 of 10

ın 06 09	05:17p Mars	sha H. Thompson				(301)430-7219		p.24
	TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CON	STRUCTION		TE SURVEY
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		HFD03-0248		B. WING			1	
NAME OF P	ROYDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE Z	PCODE	- ' 	5/08/2009
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CARECO	· · · · · · · · · · · · · · · · · · ·		WASHING	TON, DC				
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R 000	INITIAL COMMEN	NTS		R 000				
	2009 through May Persons with Men	was conducted from 8, 2009. The Group it tal Retardation (GHMF) n of seven men with vi	Home for RP) had a					
· · · · · · · · · · · · · · · · · · ·	observations, inter guardian, interview one day program,	e survey were based on the survey with residents and the horn as well as a review of a records, including income.	ind one ne and at resident					
R 122	Except as provided facility shall obtain and shall either ob District of Columbi	OUND CHECK REQUIDED IN Section 4701.8, eaction 4701.8, eaction 4701.8, eaction a criminal background tain or conduct a check a Nurse Aide Abuse For using the contract serson.	ich f check, ik of the Registry,	R 122	criminal	nan Resources Director w background check is con on for each employee prionent.	ipleted per	• • (30)0
	Based on interview records, the GHMI background check employing or using	t met as evidenced by: y and review of person RP failed to ensure cri is had been obtained to y the contract services , for 2 out of 17 direct 66 and \$10)	nei minal sefore of an			·		
	The findings includ	le:						! !
	Qualified Mental R (QMRP) agreed to needed to show ex checks for all staff May 8, 2009, begin	t approximately 4:50 Fetardation Professional provide documentation idence of criminal backemployed in the facilitating at 12:58 PM, revealed no document	al na ekground y. On iew of		•			
	ition Administration	,			1			
Mars	en H. Hu	onegra			~	TITLE		(X6) DATE
		DER/SUPPLIER REPRESENT	TATIVE'S SIGN	MATURE (Diredz	or of Disability	Services	6/5/06
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Marsha H. Thompson